MEDICAL CARE AND HOSPITALIZATION OF THE INDIGENT SICK*

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It may be accepted as a fact that there exists among the public a considerable amount of dissatisfaction in regard to the present system of medical practice. This dissatisfaction does not imply any criticism of the medical profession. Indeed, it is the very reverse because it grows out of an appreciation of medicine and a desire to profit more fully by what medicine has to offer for the benefit of mankind.

The cause of dissatisfaction is an economic one. The real problem arises out of the inability to pay for such medical services as are required. Under the present social structure there are large classes of the population that cannot pay for adequate medical care and consequently are going without it. This is the case in spite of the fact that members of the medical profession furnish medical care for the indigent largely without remuneration.

Persons who have only a vague notion of the problem and who are largely unacquainted with the medical aspects of it are often heard to say that the cure for this unsatisfactory condition is "Socialized Medicine" or "State Medicine." Indeed so many schemes which are economically unsound or defective from a medical point of view have been advanced under the names "Socialized Medicine" or "State Medicine" that the medical profession as a whole has a distinctly unfavorable reaction when any change in the present system of medical practice is advanced.

This is unfortunate from every standpoint. While this "stand-off" attitude prevails, steps are being taken without full consultation with or approval of organized medicine which may bring about drastic changes in the system of medical practice. The medical profession must take the

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lead in passing upon the advisability of these changes or else unsound legislation will be passed and standards of practice distinctly detrimental to the profession will be established.

It is my purpose to outline some of the changes in the belief that once you recognize their imminence and their import, you will use your influence to have the medical profession take the lead in co-ordinating these changes into a unified plan which is socially desirable and consonant with the highest standards of the medical profession. Some of the changes I believe you will find undesirable; others you will want to encourage and develop.

The first change in our system of medical practice that comes to mind is the development of the medical and nursing service of the Home Relief Department. The Emergency Relief Act of the State of New York defines "medical care" as one of the necessaries of life to be provided to all persons who are found to be in dire want owing to the economic depression. How is the medical care provided in New York City?

Any person receiving home relief who believes himself to be in need of medical attendance, or medicine, by calling Home Relief headquarters, may have a doctor immediately dispatched to his home without incurring any financial obligation. There are 2811 doctors now employed by Home Relief to give such medical care at $2 a visit—2811 "contract doctors." That fact alone should startle us into a realization that new standards of medical practice may be developing almost without the knowledge of the organized medical profession. Any practitioner licensed to practice, who is not shown to be in bad standing in his neighborhood, may have his name placed on the reserve panel to answer these home relief calls, by filling a simple application. So far as I can find out no effort is made to determine the type of practice or length of experience of the applicant doctors, either at the time their applications are accepted or when they are assigned to a particular case. As the calls

come in, the doctors on the panels are assigned in rotation, although the regulations provide that if a patient so requests, and the relief authorities find it practicable, the "family doctor" will be sent. "Family doctor" is defined as a practitioner who has treated the patient prior to the date when the patient went on the home relief rolls. The doctors on the panel are allowed to continue their private practice, and they may reject any home relief call.

The "contract doctor" is allowed to make up to 5 calls upon the patient at his home without further authority from the relief officials, charging the Relief Administration at the $2 rate—or a total of $10. If further calls are required, or if he thinks a nurse is needed, or that hospitalization is indicated he informs relief headquarters and they decide whether his request shall be carried out. If they approve the suggestion that a nurse be sent, the visiting nurse association which serves the neighborhood where the patient lives, is called. For each visit the "contract nurse" receives $1.00. I understand that the nursing organizations contend that when a home relief call for medical care is received, a nurse should first be sent, and she should recommend whether a doctor is needed—rather than having the doctor call first and determine whether a nurse is needed. The doctor also recommends whether medicine is needed and if the relief administration officials approve the request, they authorize one of the pharmacies on their approved list to fill the prescription. These medicines are charged for at a fixed price agreed upon in advance between the pharmacists and the relief officials. No contribution is made out of home relief funds to the doctors connected with hospitals for the hospital services they render to home relief patients. The government expects the doctors to continue their wonderful record of hospital care of the indigent sick of New York on a charity basis.

Over 900 home relief calls are answered on some days, and the scope of the service is increasing more rapidly than any other relief division as the persons on home relief learn about it. During November the service here in New York City cost approximately $92,000 for doctors and nurses and

for medical supplies. If the salaries of the office staff of the service be included, the November cost was about $150,000, or at the rate of $1,800,000 per annum.

The public unemployment relief work has a second department of more than passing interest to the members of the medical profession. This is the so-called Disability Division of the Work Relief Department. In this division are treated all the accidents and sicknesses of the persons engaged on public works' projects. There are only 34 doctors employed here. But an entirely different method is followed. The doctors in the Disability Division are on a salary ranging from $27 a week to $40 a week, or at an annual rate of $1,404 to $2,080. These practitioners punch the time clock, to all practical purposes. They are employed to work from 9 A.M. to 5 P.M., and timekeepers are hired to see that they keep these hours. These doctors are allowed to continue private practice in the evenings, except that they are not allowed to take patients who are receiving medical attention from the work relief department. The doctors so employed are chosen primarily from lists submitted by the local medical societies, although any other doctor is eligible to apply to be placed on the panel. The financial want of the applicant is considered, but the controlling factor is stated to be the applicant's "efficiency." If the doctor in any case recommends that medicine be given the patient, or that hospital treatment is required, these requests are passed upon by the medical head of the Disability Division. The reports of the Disability Division for the month of October show that the salaries of the doctors totalled $4,480, whereas if the professional services had been rendered on the flat $2 fee plan, the cost would have been about three times as much, or $12,878.28.

It will be noticed that no money is paid out of home or work relief funds to voluntary hospitals to reimburse them for care of the patients. It is true that the City contributes almost 15 millions of dollars out of its general fund to private hospitals and private charitable institutions to aid their budgets. Yet even with this public aid, we realize that

voluntary hospital budgets do not balance today. Private charity can no longer carry the load. Experience in England during the past ten years and in this country during the last four years, has demonstrated that it is practicable to balance these hospital budgets by providing hospital care for the wage earner and low salaried worker on a pay basis rather than a charity basis, provided the payments are small and a large group co-operates in spreading the risk of hospital expense.

A year ago a group of hospital presidents and the Hospital Conference of the City of New York, made up of the superintendents of 73 New York hospitals, formally requested the United Hospital Fund to appoint a committee to develop, if possible, such a plan for New York City. The plan has been developed, approved by the State Superintendent of Social Welfare, and is about to be actively promoted. A non-profit corporation is to be established, known as the Associated Hospital Service of New York. The affairs of the corporation will be controlled by eleven directors, elected annually by a voting membership comprising the presidents of the Hospital Conference of the City of New York, the Brooklyn Hospital Council, the five County Medical Societies of Greater New York and the Medical Society of the State of New York, and the trustees of the United Hospital Fund. Every voluntary hospital in New York City and the Metropolitan Area meeting the standards of the American College of Surgeons will be eligible to membership, and certain proprietary hospitals maintaining equal standards may be eligible to participate, if approved by the State Department of Social Welfare.

The Associated Hospital Service of New York will undertake the solicitation of annual subscriptions among employed groups, arranging with employers and employees for payroll deductions. The cost to subscribers will be 90c. per month or $10 per year. Such subscriptions will apply to employed persons only and not to their dependents, although dependents may be included later as the plan develops.

A subscription will entitle the subscriber to three weeks of "semi-private" hospital care during the contract year after a ten day waiting period immediately following the signing of the contract (except in case of accident in which case the waiting period would not apply), and a ten month waiting period for obstetrical cases. Admission to the hospital will be granted only on the recommendation of the subscriber's personal physician. The patient will be subject to the regular rules of the hospital and would make his own arrangements with his physician in respect to fees for medical service. The Associated Hospital Service of New York will reimburse the hospital members at a flat rate per day probably six and possibly seven dollars per day.

In addition to so-called "group hospital" plans, such as the one just described for New York City, there has been a rapid development in this country during the past few years of various plans for group medical service. I have time to mention only one type of many that are being tried. Fifty-five surgeons and physicians in the Los Angeles area have united in a profit-making plan whereby at the present time over 12,000 persons pay $2 per month and receive in return complete medical and surgical attention, including diagnosis, clinical or laboratory tests, x-ray examinations, treatments, operations, professional consultations and visits. Also, the subscribers are entitled to receive without charge all medicines prescribed by the medical attendants, with minor exceptions. Also hospitalization, where such treatment is prescribed by the medical attendant, providing the period of stay shall not be more than three months in any one year. No dental service is included. Dependents in the family of the subscriber also receive certain free medical services, and reduced rates on all treatments and consultations.

This profit-making group plan is being bitterly opposed by the State and County medical societies where it is being carried on. The two practitioners who conduct the service have been expelled from the local society and thus have lost their membership in the American Medical Association.

There is some talk of excluding them from hospitals of recognized standing. The opposition of the medical societies is based on the theory that the plan destroys the personal relationship of doctor and patient; also that it will surely lead to competitive profit-making groups, and eventually to price-cutting and unethical practices between rival profit-making groups.

The fifth and last development to which I wish to refer is the recently announced plan of the Canadian Medical Association for a comprehensive system of compulsory health insurance for Canada. The Association represents the entire medical profession of Canada, and its findings represent the result of studies carried on since 1929. While many practitioners did not approve of health insurance, they were willing to have the Association develop a plan because of the unfortunate results experienced in other countries where health insurance legislation was adopted without consultation with organized medicine.

The stated purpose of the Canadian health insurance plan is to make available for every person in Canada the full benefits of curative and preventive medicine irrespective of the ability of the individual to pay for it; and at the same time to insure the practitioners of medicine and others associated in providing medical care, a reasonable remuneration for their services. All persons with dependents who have an annual income of less than $2,500, and all persons without dependents having an annual income of $1,200 or less, and all indigents, together with dependents of all the classes set forth above, are the persons to be included in the Canadian plan.

Wage earners and salaried employees included in the insured classes, are to have a small tax or contribution deducted each week from their wages or salaries. Rural land owners contribute by paying a land tax; for rural non-land owners and urban employers, a poll tax is provided. Employers are also to contribute, on the theory that they have a direct interest in the physical and medical health of their employees. The State is also asked to make

a contribution on behalf of the indigent. Every insured person, including the indigents, is to be entitled to specialist and consultant medical service, visiting nurse service in the home, certain hospital care, pharmaceutical service and dental service.

Under the plan every qualified licensed practitioner will be entitled to practice. When a person becomes sick he will go to the doctor of his own choice in his local community and receive the medical care referred to above. There is to be no supervision by the State or by the administrators of the health insurance plan as to what doctor should be chosen. The doctor receives his pay from the insurance fund. The method of payment will vary according to the type of community. In those areas where there is not sufficient population to maintain even one general practitioner he will be paid a regular salary. In other areas the method of payment will be decided upon by the practitioners in that area. They might be paid a flat amount per year for each insured person who comes to them for professional services; or there might be a rate set by the local medical society for each particular medical act. The local medical society would also determine the fees for specialist's and surgical acts. There would be no cash payments under the plan and no attempt to compensate for loss of wages during the period of illness.

The health insurance would not interfere in any way with the continuation of public health services, such as collection of vital statistics, control of communicable diseases, tuberculosis sanatoria, mental hospitals and school health services.

These five plans which I have discussed justify, I believe, the statement I made earlier: that many sweeping changes are being made and others are about to be made in our community in the system of medical practice. Politicians will continue to present new plans as long as there continues to be widespread dissatisfaction with the present system. We must insist that the plans shall be sound from a medical standpoint before any are adopted, otherwise

they cannot be successful. Because of the prejudice against the terms "State Medicine" and "Socialized Medicine," and the uncertainty as to their meaning, I think they should not be used to denominate any of the proposed new plans. Let each plan be considered on its merits regardless of the name by which it is described. My own conclusion is that the most orderly way to proceed in New York State is for organized medicine to make an immediate study and suggest changes in our public health program. Such a study would be of decisive importance to the State, and might well serve to prevent enactment of ill-advised legislation.

PRESENTATION OF THE ACADEMY MEDAL TO DR. CHARLES NORRIS

Stated Meeting of The New York Academy of Medicine
Held December 6, 1934

Dr. James Ewing who introduced Dr. Norris said:

Mr. President:

I have the honor of presenting to you as most worthy of the Medal of The New York Academy of Medicine, one who is, first of all, a gentleman and a loyal friend, a man endowed with strong mind of judicial cast, a scholar of high attainments, trained in the sciences of pathology and bacteriology in each of which he has made substantial contributions, whose chief distinction lies in providing the City of New York, for the first time in its history and against many difficulties, with a sound medico-legal organization, thereby placing this community and all its citizens as well as the medical profession under lasting obligation, the first Chief Medical Examiner of the City of New York, Dr. Charles Norris.